

# PIPP

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TIME SUBMITTED	01-MAR-2016 11:59PM	WORD COUNT	3256
SUBMISSION ID	53631995	CHARACTER COUNT	18940

**Personal Professional and Inter-  
professional Practice**

**Reflective case study**

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**1<sup>st</sup> March 2016**

**Adult Health: Year 3**

**C327879**

This essay focuses on an ethical dilemma encountered whilst on placement in a large teaching hospital trust in the North of England. The emphasis of the essay aims to explore the dilemma and the ethical, legal and professional issues that arose from the incident. I will reflect on the issues, consequences and feelings of the patient and myself throughout this essay and how the dilemma could have been handled more appropriately. I will also discuss relevant literature and critically analyse the issues raised. Reflection aids learning and can influence future practice with the aim to improving patient care. Bredon (2012) suggests reflection provides an opportunity for health care professionals to challenge current practice and encourages transformative action which in due course will lead to improvements in the quality of care being delivered. John's model of structured reflection (1995) is a widely used appropriate framework for this essay, involving a range of cue questions to guide, structure, analyse and reflect on this ethical dilemma.

During placement on a ward consisting of 16 source isolation rooms, I cared for a patient who was admitted with an infected leg abscess. The 35 year old male had a past medical history as a previous intravenous drug user with poorly controlled HIV. This caused him to be immunosuppressed and very weak on arrival, which in turn delayed his healing rate and the recovery of his abscess. Whilst in hospital, he contracted MRSA in his wound and source isolation and decolonisation were commenced as per the local trust's policy. The patient was prescribed anti-bacterial body wash to wash in, everyday for 5 days to eliminate the MRSA as advised by the Health Protection Agency (2007). However, without reasons given, the patient refused to wash in the scrub; the patient maintained full capacity and had the right to refuse treatment. In the morning handover, the nursing staff were instructed to try and persuade the patient to consent to washing in the scrub. Over the next few days the staff repeatedly tried to persuade the patient to wash in the scrub but the patient continued to decline treatment at every point.

The NMC code encompasses the practice standards which student and registered nurses must adhere to at all times to be a compassionate, competent nurse (NMC, 2015). One professional standard outlines that nurses must "respect, support and document a person's right to accept or refuse care and treatment" (NMC, 2015) and this was not adhered to by some members of staff. Griffith (2015) suggests that nurses have a duty of care to respect the voluntary, informed refusal of treatment from service users who maintain full capacity. The patient made his decision and clearly declined the treatment; however certain staff did not support his decision and therefore did not respect his self-determination or autonomy. The British Medical Association (2016) defines autonomy as a competent person's right to make informed decisions about their own care and treatment without external constraints, even if not seen as sensible to others. The mental capacity act (2005) states that "a person is not to be treated as unable to make a decision merely because they make an unwise decision". The nurses had a duty of care to take into account and consider the patient's views, values and belief in order to empower the patient and promote autonomy.

Beauchamp and Childress (1989) four principle approach is based on four moral principles: respect for autonomy, non-maleficence, beneficence and justice. Gillon (1994) suggests that this approach can be adopted by anyone in the healthcare system as they will share a

common moral commitment, common moral language and common analytical framework for reflecting on problems faced with ethics in healthcare. Griffith (2014) implies the principles are considered to incorporate the majority of the moral issues that occur in the healthcare setting. Gillon (1994) states that the principles do not resolve the dilemma, but provide health care professionals with support to make decisions when reflecting on moral issues.

The Department of Health (2012b) 'No decision about me, without me' proposes to ensure service users have more control and say over their care, enabling them to make informed decisions, as a means of securing better care and better outcomes. McKinnon (2014) describes concordance as a partnership between a service user and health care professional on which shared decision making and care planning is formed. The Kings Fund (2014) promotes the significance of shared decision-making and the need for health care professionals and service users to work together to make choices about care, based on clinical evidence and the patient's preferences. Pollard et al (2015) suggest to successfully achieve shared decision making between service users and clinicians is difficult unless both have the intent to participate in mutual information exchange and understanding of the patient's wishes. The patient was not involved in the decision making process of his treatment and although he refused, clinicians persisted to try and treat him against his will. By doing so, the patient is not in control of decisions regarding his care and therefore not receiving high quality care and respect he deserves.

The NHS England (2015) suggest that in health care when a decision cannot be made, a review of options should be made available as well as the service user participating actively with the clinician to make a shared decision. The patient was only supplied one treatment option and was not actively involved in the decision. The Department of Health (2012b) suggest that greater patient involvement in their own care choices will increase and encourage better shared decision making, care planning and support for self-care. McKinnon (2014) suggests that pursuing concordance may positively affect practice by assisting service users in taking control of their own health. Rather than insisting on one particular care path, the nurses could have discussed wider options and continually referred back to the patient's thoughts and feelings on what he considers best suited for him.

The patient maintained full capacity and therefore he has the right to deny any care or treatment if he wishes. The mental capacity act (2005) requires health care professionals to assume the person has the capacity to make informed decisions about their own care, even if it is seen as unwise to others. In this dilemma the patient clearly had capacity to make a decision although it was one that the staff saw as unwise. Regardless, and in keeping with NMC guidelines, this decision should be upheld, respected and supported by the professionals. Griffith (2014) states health care professionals must promote patient autonomy and self-determination of service users who have decision-making capacity.

As the patient had full capacity, it is a general, legal and ethical principle that valid consent is gained before any care is given. Bell (2013) claims that consent presents the most challenging legal and ethical dilemmas and patient autonomy should always be the guiding principle. Gillon (1994) outlines the importance and the obligation to obtain informed consent before any care or treatment is given. Taylor (2014) suggests three requirements

that must be provided for valid consent to be obtained. These are: the patient to be fully informed about the treatment, trust the information provided, the opportunity to evaluate the information and eventually come to a voluntary decision. The Department of Health (2009) also highlights the importance of ensuring that consent is agreed voluntarily by the service user and that relevant and sufficient information is given to permit valid consent. The patient did not give consent for the treatment to commence but is still being prompted and advised daily to undergo the treatment against his will. It could be considered immoral and unprofessional that the staff are trying to encourage treatment without consent. Bell (2013) states that treating a patient without consent is a breach of professional guidance and codes of conduct e.g. the NMC code. Felzmann (2012) implies that the central ethical value in informed consent is the service user's autonomy and further states that the patient's care/treatment decisions are perceived as an expression of their autonomy. Rather than pressuring for this treatment, open dialogue should be conducted regarding all other options available.

The NMC code (2015) reinforces a moral and professional obligation to act in the best interest of service users, providing high quality care whilst considering the principles of beneficence and non-maleficence. Beauchamp et al (2013) state that both of these principles play a significant role in medical ethics. Gillon (1994) expresses healthcare workers must consider these principles together with an overall aim of producing benefits that outweigh harm to the service user.

The proposed treatment would clearly benefit the patient's physical health and enable a faster recovery for the infected wound. Griffith (2015) states that the majority of times, healthcare professionals will accept the decision to refuse treatment as a choice patients are entitled to make. It was clear that the staff wanted the patient to recover as quickly as possible without any risk of deterioration and this could be why they insisted on the patient being treated. It would seem morally wrong not to treat a patient as that would most likely cause unnecessary further harm, in this respect I understand the persistence of the staff.

Griffith (2015) suggests that refusing treatment which could have serious consequences for the service user makes it more difficult for clinicians to accept. By staff ignoring the patient's refusal he became frustrated, non-compliant and sometimes aggressive towards staff. He felt the staff were not respecting his rights or treating him with compassion or kindness which led him to refuse other treatments including certain medication and antibiotics. Doherty (2014) insists that person-centred care can only be reached by fulfilment of the service user's cooperation and by encouragement of their contribution. The patient was not cooperating due to the fact that he felt he had no choice and that he had no control over his care. Barker (2011) suggests that if health professionals are not ethically vigilant in addressing conflicts which arise in practice, they may develop into serious threats to the welfare of those in the professionals' care. In this sense the nurses could be causing more harm by insisting on the patient washing and not focusing on the treatment to heal the infected leg abscess and controlling his HIV. This would cause further complications physically to the patient and may cause psychological issues too.

The Department of Health; compassion in practice (2012a) outlines the importance of clear, effective communication and the need to ensure patients have a role in their care as well as decision making alongside the team. Gillon (1994) believes good communication is key for

health care professionals to respect patients' autonomy and outlines the necessity to give patients adequate information about any proposed care or treatment. Personally, I feel that the patient did not receive enough detail about the risks and benefits of the treatment and the care team expected him to just agree. The NMC (2015) states the importance of supplying the relevant information a patient needs to know regarding their health, care and ongoing treatment. The doctor spoke to the patient with very little detail regarding the treatment but emphasised the need to participate. Beauchamp (2013) suggests that a "patient's autonomy may be compromised by a clinician due to an assumption of unwarranted authority given over the patient". The Doctor did not seem interested in the patient's opinion and just expected him to agree to what he was advising, as he had the expertise and authority of a doctor. The department of health (2012b) suggest clinicians should deliver their clinical expertise about a treatment, while accepting patients are the experts in their condition and have knowledge of their individual preferences. Knowledge from both areas ensures the patient is involved and in control of their own care and treatment.

The patient was seeing different doctors every day so there was no continuity, making it difficult to build a therapeutic relationship. The King's Fund (2010) state there is a wide range of evidence to support that a good quality therapeutic relationship can improve patient satisfaction as well as increasing compliance. The 6C's (2012) state that "developing and sustaining a positive therapeutic relationship with service users forms the basis of all care". Doherty (2014) also agrees with this statement by suggesting the formation of a therapeutic relationship with a service user is essential to accurately assess and understand the patients' needs, therefore ensuring effective person-centred care.

A factor affecting the patient involved the struggle with withdrawal symptoms which made him quite agitated and frustrated with the situation. The patient was prescribed analgesia but requested the medication before it was safely allowed to be given again. This caused the patient to become frustrated with the staff and therefore made him less willing to co-operate with the clinicians. It may have been more appropriate for the doctor to address his addiction and pain needs to ensure the patient is as comfortable and relaxed as possible before suggesting the treatment. In an ideal system, time should be made to deal with patients as in this dilemma whenever the patient is most relaxed and receptive rather than the time being chosen to suit ward routine and convenience. This highlights the need for therapeutic relationships and the effects it can have on patients if successful. McKinnon (2014) suggests that a relationship of mutual respect will encourage service users to act on health care professional's advice when they have confidence that it is the right option for them.

By building a rapport with the patient over a few weeks, the patient felt he could express his feelings and concerns to me regarding the situation, explaining no one had given him the appropriate information or involved him in any of his treatments. I felt the patient was not being treated holistically and his needs were not being met. Although I had a therapeutic relationship with the patient, I felt it was unprofessional to ask the patient to agree to the treatment when he clearly did not want to. By doing so, I was adhering to the NMC code

(2015) standard respecting the patients' rights and individual choice as well as responding compassionately and politely to his decision.

A factor that could be affecting the nurse's persistence could be due to the lack of source isolated beds in the hospital; the ward was constantly under strain to provide them. The pressure for the source isolation room may have made the nurses push the patient to be treated so the side room became free for another patient in need of source isolation. Although this must be a pressure on the clinical staff, the patient has a right to refuse treatment and this should be supported.

This experience has highlighted the importance of building a rapport to gain the patient's trust and respect and in turn this enables care providers to give the highest quality of care possible. Rapport empowers the patient which promotes independent decision making and respect between patient and care provider, therefore building rapport aims to ensure the patient's best interests remain at the heart of decision making at all times. Being involved in this ethical dilemma has helped me develop as a student nurse from witnessing the way in which others acted in a way they believed was right, rather than listening to the patient's wishes. This outlined the significance of listening and understanding someone's decision about their care and not pushing my own beliefs and values on to them.

John's model of structured reflection (Johns, 1995) was a useful tool in reflecting on this ethical dilemma by providing clear, relevant cue questions that helped structure this assignment. However, it proved difficult to include literature and therefore I struggle to incorporate evidence to support the cue questions.

As a 3<sup>rd</sup> year student nurse with ambitions of becoming a newly registered nurse, dilemmas like this have enhanced my ability to challenge my own thoughts and that of other health care professionals. Taylor (2000, cited in Bredon, 2012, p10) states that reflection is a critical component of the continuous professional development cycle and enables practitioners to objectively review their practice thereby enhancing their performance. Reflecting on this dilemma in particular has increased my confidence to question my own practice and that of others and in future I will act as an advocate for patients that I feel are vulnerable or receiving poor practice which is affecting their care (NMC, 2015). Although I understand the strain on the NHS and the need for beds and the importance of source isolation rooms, health care professionals must put aside the pressure from the hospital and treat the patient with dignity and respect. Overall, ethical dilemmas will occur, however I can now support myself, staff and patients better as a consequence of this experience. By implementing the 6C's (2012) and upholding the NMC Code (2015) of professional standards I believe I can minimise the effects of ethical dilemmas and become a competent compassionate registered nurse.



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